

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR STIMULANTS AND RELATED AGENTS COMPLETION INSTRUCTIONS**

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and dispensing physicians are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents form, HCF 11097. Pharmacy providers are required to use the PA/PDL for Stimulants and Related Agents to request PA by using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197 or (608) 221-2096.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), HCF 11018, and the appropriate PA/PDL form by fax to Wisconsin Medicaid at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to submit a copy of the prescription.

Element 4 — Drug Name and Strength

Enter the drug name and strength.

Element 5 — Date Prescription Written

Enter the date the prescription was written.

Element 6 — Directions for Use

Enter the directions for use of the drug.

Element 7 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or the description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis for stimulants must be one of the approved stimulant diagnosis codes.

Element 8 — Name — Prescriber

Enter the name of the prescriber.

Element 9 — Drug Enforcement Agency Number

Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. These default codes must *not* be used for prescriptions for controlled substances. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

Element 10 — Address — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code.

Element 11 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

Element 12 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 13 — Date Signed

Enter the month, day, and year the PA/PDL for Stimulants and Related Agents was signed (in MM/DD/YYYY format).

Element 14

Check the appropriate box to indicate if the recipient has taken a non-preferred stimulant and related agent for more than 30 days outside the Wisconsin Medicaid system and had a measurable, therapeutic response.

SECTION IIIA — CLINICAL INFORMATION FOR STRATTERA

Include clinical information explaining the need for the drug requested. In Elements 15 through 19, check "yes" to all that apply.

Element 15

Check the appropriate box to indicate whether or not the recipient has a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) *and* Tourette's Syndrome or a history of tics.

Element 16

Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD *and* obsessive compulsive disorder.

Element 17

Check the appropriate box to indicate whether or not the recipient has a medical history of substance abuse or misuse. If yes, explain in the space provided.

Element 18

Check the appropriate box to indicate whether or not the recipient has a serious risk of diversion. If yes, explain in the space provided.

Element 19

Check the appropriate box to indicate whether or not the recipient has tried and failed or had an adverse drug reaction to a preferred stimulant. If yes, indicate in the space provided the failed drug(s) or the adverse reaction experienced.

SECTION IIIB — CLINICAL INFORMATION FOR PROVIGIL

Include diagnostic and clinical information explaining the need for the drug requested. In Elements 20 through 23, check “yes” to all that apply. For PA approval, providers must check “yes” for Element 20 **or** check “yes” for Elements 21, 22, and 23.

Element 20

Check the appropriate box to indicate whether or not the recipient has a diagnosis of narcolepsy or idiopathic hypersomnolence, obstructive sleep apnea/hypopnea syndrome (OSAHS), or shift work sleep disorder (SWSD). Indicate the diagnosis in the space provided.

Element 21

Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD.

Element 22

Check the appropriate box to indicate whether or not the recipient has tried and failed or had an adverse drug reaction to **two** preferred stimulants. If yes, indicate in the space provided the failed drugs or the adverse reaction experienced.

Element 23

Check the appropriate box to indicate whether or not the prescriber has peer-reviewed medical literature to support the proven efficacy of the requested use of the drug for ADD or ADHD. If yes, indicate in the space provided the medical literature references.

SECTION IIIC — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS AND RELATED AGENTS

Include diagnostic and clinical information explaining the need for the drug requested. In Elements 24 and 25, check “yes” where applicable.

Element 24

Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD.

Element 25

Check the appropriate box to indicate whether or not the recipient has tried and failed or had an adverse reaction to a preferred stimulant. If yes, indicate in the space provided the failed drug(s) or the adverse reaction experienced.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 26 — National Drug Code

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 27 — Days’ Supply Requested

Enter the requested days’ supply.

Element 28 — Wisconsin Medicaid Provider Number

Enter the provider’s eight-digit Wisconsin Medicaid provider number.

Element 29 — Date of Service

Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 30 — Place of Service

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
00	Not Specified
01	Home
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Element 31 — Assigned PA Number

Record the seven-digit PA number assigned by the STAT-PA system.

Element 32 — Grant Date

Record the date the PA was approved by the STAT-PA system.

Element 33 — Expiration Date

Record the date the PA expires as assigned by the STAT-PA system.

Element 34 — Number of Days Approved

Record the number of days for which the PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 35

Indicate any additional information in the space below. Submit additional information on a separate sheet if necessary.